

SERFF Tracking Number: CAIC-128398701 State: Arkansas  
Filing Company: Continental American Insurance Company State Tracking Number:  
Company Tracking Number: 8650  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Accident 7800  
Project Name/Number: Revised ACC7800 Enrollment Form /

## Filing at a Glance

Company: Continental American Insurance Company

Product Name: Accident 7800

SERFF Tr Num: CAIC-128398701 State: Arkansas

TOI: H02G Group Health - Accident Only

SERFF Status: Closed-Approved-  
Closed State Tr Num:

Sub-TOI: H02G.000 Health - Accident Only

Co Tr Num: 8650

State Status: Approved-Closed

Filing Type: Form

Author: Sara McCormick

Reviewer(s): Rosalind Minor

Date Submitted: 05/23/2012

Disposition Date: 05/23/2012

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Revised ACC7800 Enrollment Form

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Other

Explanation for Other Group Market Type:  
Unions

Overall Rate Impact:

Filing Status Changed: 05/23/2012

Deemer Date:

State Status Changed: 05/23/2012

Submitted By: Sara McCormick

Created By: Sara McCormick

Filing Description:

Corresponding Filing Tracking Number:

This enrollment form is being filed for your review and approval. This is a new filing and will not replace any other forms on file with your department.

The enrollment form will be used with our Group Accident product, series CAI7800AR, et al. (This filing was approved by your department on 12/05/2011. Its SERFF tracking number is CAIC-127863751.)

If you have any questions or require additional information, please contact Sara McCormick either at 1.888.730.2244, ext. 4952 or at [companycompliance@aflac.com](mailto:companycompliance@aflac.com). Thank you for your consideration in this matter.

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Sincerely,

James J. Hennessy, AIRC, CCP  
Vice President, Compliance  
/scm  
State Narrative:

## Company and Contact

### Filing Contact Information

Marsha Tate, Analyst MTate@caicworksite.com  
2801 Devine Street 803-461-4478 [Phone]  
Columbia, SC 29205

### Filing Company Information

Continental American Insurance Company CoCode: 71730 State of Domicile: South Carolina  
2801 Devine Street Group Code: Company Type: LAH  
Columbia, SC 29205 Group Name: Continental Amer Ins State ID Number:  
Co  
(803) 256-6265 ext. [Phone] FEIN Number: 57-0514130  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation: South Carolina's retaliatory fee is zero dollars; therefore, we are submitting the following:  
  
1 application x \$50.00 = \$50.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	\$50.00	05/23/2012	59367251

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/23/2012	05/23/2012

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## **Disposition**

Disposition Date: 05/23/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* CAIC-128398701      *State:* Arkansas  
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Form</b>	Enrollment Form	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: C70206

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 05/23/2012	C70206	Application/ Enrollment Form	Application/ Enrollment Form	Initial		0.000	C70206 Enrollment Form.pdf



**CONTINENTAL AMERICAN  
INSURANCE COMPANY**

**ENROLLMENT FORM**

Please Mail: Post Office Box 427  
Columbia, South Carolina 29202  
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
<b>Accident</b>		
Endorsement:		
EFFECTIVE DATE:		
FOR AGENT USE ONLY		
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Enrollment
<input type="checkbox"/> Newly Eligible		
Deduction start date _____		

[Employee] Name/Owner (First, MI, Last)		Social Security Number/ID Number	Gender	Date of Birth
Street Address		City	State	ZIP
[Employer]	Job Class/Occupation	Location	Hire/Change of Status Date	
Hours Worked	Daytime Phone Number ( )	Beneficiary Name/Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)		Gender	Spouse's Date of Birth	
		[Employee]	Spouse	
[Are you currently working [part-time;full-time] for the [employer] listed above?]		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
[Are you now disabled or unable to work?]				<input type="checkbox"/> YES <input type="checkbox"/> NO

**List all eligible children for whom you are proposing coverage (from Youngest to Oldest):**

Name	Gender	Date of Birth	Name	Gender	Date of Birth

<b>ACCIDENT</b> <input type="checkbox"/> 24 Hour <input type="checkbox"/> Non-Occupational] Plan _____	<input type="checkbox"/> New Coverage] <input type="checkbox"/> Change in Coverage]
<input type="checkbox"/> [Employee] <input type="checkbox"/> [Employee] & Spouse] <input type="checkbox"/> [Employee] & Children] <input type="checkbox"/> Family]	[Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No]
[ <input type="checkbox"/> Sickness Rider] [ <input type="checkbox"/> Dependent Rider] [ <input type="checkbox"/> Catastrophic Rider] [ <input type="checkbox"/> Total Disability Rider] [ <input type="checkbox"/> Gunshot Wound Rider]	
Cost per pay period:[Including any Riders]\$_____	
[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]	

To the best of my knowledge and belief, the answers to the questions on this Application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

Does this coverage replace or change any existing insurance?  YES  NO

If yes, provide carrier and policy number: \_\_\_\_\_

[If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.]

Coverage will not become effective unless you are employed [part-time; full-time] on the enrollment date and on the effective date.

CERTIFICATION: I have read the completed Application and I realize any false statement or misrepresentation in the Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Application is approved and the necessary premium is paid.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

[I authorize [my employer] to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.]

[I certify that I currently work [part-time; full-time] for the [employer] listed on this application [and that my spouse is not currently disabled or unable to work].]

**A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an Application or filing a claim that contains any false or deceptive statement.**

Date: \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Agent \_\_\_\_\_ Agent No.: \_\_\_\_\_ State of Enrollment: \_\_\_\_\_



### Things to Consider Before Replacing Your Existing Insurance Coverage

Aflac’s goal is to provide you with outstanding insurance products that offer important financial protection to you and your loved ones in the event of an accident or illness. To best serve our customers, we offer a robust portfolio of products designed to respond to a variety of needs and circumstances. If you are thinking about replacing one type of policy for another, please be aware that there are important differences between insurance products—specifically group products versus individual products. These differences may affect your coverage. Before making a change to any existing coverage you may have, please make sure to carefully compare the benefits provided by your existing policy and the proposed replacement coverage. Among the items you should consider are the following:

1. If you are currently receiving treatment for an injury or illness: Your new coverage will not cover claims for treatment received as a result of injuries or illnesses diagnosed prior to its effective date.
2. If you terminate existing coverage, no benefits will be paid for diagnoses or treatments you receive after the termination date.
3. Benefits of your existing policy and the replacement coverage you’re considering may be different, and you may be subject to new waiting periods and/or coverage exclusions due to preexisting conditions.
4. If you terminate an existing policy, you will lose any accrued benefits. Any such accrued benefits cannot be transferred to new coverage.
5. Individual insurance coverage is guaranteed-renewable and cannot be cancelled for any reason other than non-payment of premium.
6. Group insurance coverage is not guaranteed-renewable. If the master policy held by your employer or organization is cancelled, your coverage terminates.
7. Individual insurance coverage is fully portable. If you leave your current job, you can retain your individual insurance coverage.
8. Group coverage has limited portability. If you change jobs, you may not be able to retain your coverage.

**By signing below, I acknowledge that I have received this notice and wish to apply for new coverage.**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Applicant’s Name (printed) \_\_\_\_\_

Address (printed) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Telephone \_\_\_\_\_ ]

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	05/23/2012

**Comments:**

Our Group Accident product, series CAI7800AR, was approved by your department on 12/05/2011, with an Flesch Reading Score which exceeded your minimum requirement of 40. This enrollment form is intended to be used with that product.

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application	Approved-Closed	05/23/2012

**Comments:**

This filing is solely for an application form. Our Group Accident product, series CAI7800AR, was approved by your department on 12/05/2011.